County of Loudoun, VA
Certification of Health Care Provider
For Serious Injury or Illness of a Covered Servicemember
Family and Medical Leave Act of 1993 – "FMLA"

To be completed by the treating physician and submitted to Benefits / Human Resources.

Employer Name: **County of Loudoun, VA**

Contact Information: **Barbara Wooten, Human Resources / Benefits**
1 Harrison St SE, MSC 41A
Leesburg, VA 20177
(703) 771-5970

Section I: Requires completion by the EMPLOYEE and/or the COVERED SERVICEMEMBER for whom the employee is requesting leave:

Instructions: Please complete this section before having Section II completed by a Health Care Provider. The FMLA permits an employer to require that an employee submit a timely, complete and sufficient certification to support a request for FMLA leave due to a serious injury or illness of a covered servicemember. Your response is required to obtain or retain the benefit of FMLA-protected leave. Failure to do so may result in a denial for an employee's FMLA request.

Part A: EMPLOYEE INFORMATION

Name of Employee Requesting Leave to Care for Covered Servicemember:

_____

Name of Covered Servicemember (for whom employee is requesting leave to provide care):

_____

Relationship of Employee to Covered Servicemember Requesting Leave to care:

( ) Spouse ( ) Parent ( ) Son ( ) Daughter ( ) Next of Kin

Part B: COVERED SERVICEMEMBER INFORMATION

1. Is the Covered Servicemember a Current Member of the Regular Armed Forces, The National Guard or Reserves? ( ) Yes ( ) No

   If yes please provide the covered servicemember's military branch rank and unit currently assigned to:

   _____

   Is the covered servicemember assigned to a military medical treatment facility as an outpatient or to a unit established for a the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients (such as a medical hold or warrior transition unit)? ( ) Yes ( ) No

   If yes, please provide the name of the medical treatment facility or unit: _____

2. Is the Covered Servicemember on the Temporary Disability Retired List (TDRL)? ( ) Yes ( ) No

Part C: CARE TO BE PROVIDED TO THE COVERED SERVICEMEMBER

Describe the care to be Provided by the Family Member for the Covered Servicemember and an Estimate of the Leave Needed to Provide the Care:

_____

_____

_____

Section II: Requires completion by a UNITED STATES DEPARTMENT OF DEFENSE ("DOD") HEALTH CARE PROVIDER or a HEALTH CARE PROVIDER who is either: (1) a United States Department of Veterans Affairs ("VA") health care provider; (2) a DOD TRICARE network authorized private healthcare provider; or (3) a DOD non-network TRICARE authorized private health care provider:

***Instructions*:** The employee listed on page 1 has requested leave under the FMLA to care for a family member who is a member of the Regular Armed Forces, the National Guard, or the Reserves who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list for a serious injury or illness. For purposes of FMLA leave, a serious injury or illness is one that was incurred in the line of duty on active duty that may render the servicemember medically unfit to perform the duties of his / her office, grade, rank or rating.

A complete and sufficient certification to support a request for FMLA leave due to a covered servicemember's serious injury or illness includes written documentation confirming that the covered servicemember's injury or illness was incurred in the line of duty on the active day and the covered servicemember is undergoing treatment for such injury or illness by a health care provider listed above. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime", "unknown" or o\"indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave.

If you are unable to make certain of the military-related determinations contained below in Part B, you are permitted to rely upon determinations from an authorized DOD representative (such as a DOD recovery care coordinator). (Please ensure that Section I above has been completed before completing this section.) Please be sure to sign the form on the last page.

Part A: HEALTHCARE PROVIDER INFORMATION

Provider's Name: _____

Business Address: _____

Telephone and Fax: _____

Type of practice / Medical specialty: _____

Please indicate whether you are: ( ) a DOD Health Care Provider; ( ) a VA Health Care Provider; ( ) a DOD TRICARE network authorized private health care provider; or ( ) a DOD non-network TRICARE authorized private health care provider.

Part B: MEDICAL STATUS

1. Covered Servicemember's medical condition is classified as *(check one of the appropriate boxes):*

☐ **(VSI) Very Seriously Ill/Injured** – Illness/Injury is of such a severity that life is imminently endangered. Family members are requested at bedside immediately. (Please note this is an internal DOD casualty assistance designation used by DOD healthcare providers.)

☐ **(SI) Seriously Ill/Injured** – Illness/injury is such severity that there is case for immediate concern, but there is no imminent danger to life. Family members are requested at bedside. (Please note this is an internal DOD casualty assistance designation used by the DOD healthcare providers.)

☐ **OTHER Ill/Injured** – a serious injury or illness that may render the servicemember medically unfit to perform the duties of the member's office, grade rank, or rating.

☐ **NONE OF THE ABOVE** (Note to the Employee: If this box is checked, you may still be eligible to take leave to care for a covered family member with a "serious health condition" under 825.113 of the FMLA. If such leave is requested, you may be required to complete Certification of Health Care Provider Form.

2. Was the condition for which the Covered Service member is being treated incurred in line of duty on active duty in the armed forces? ( ) Yes ( ) No

3. Approximate date condition commenced:_____

4. Probable duration of condition and/or need for care_____

5. Is the covered servicemember undergoing medical treatment, recuperation, or therapy?
( ) Yes ( ) No

   If yes, please describe medical treatment, recuperation or therapy: _____

   _____

   _____

***Part C:* COVERED SERVICEMEMBER'S NEED FOR CARE BY FAMILY MEMBER**

1. Will the covered servicemember need care for a single continuous period of time, including any time for treatment and recovery ( ) Yes ( ) No

   If yes, estimate the beginning date_____end date_____.

2. Will the covered servicemember require periodic follow-up treatment appointments?
( ) Yes ( ) No

   If yes, estimate the treatment schedule: _____

3. Is there a medical necessity for the covered servicemember to have periodic care for other than schedule follow-up treatment appointments (e.g., episodic flare-ups of medical condition)?
( ) Yes ( ) No

   If yes, please estimate the frequency and duration of the periodic care:_____

   _____

   _____

   _____

***Part D:* Certification of Health Care Provider**

_____ _____
Signature of Health Care Provider Date

Please return this completed form to the patient.